SEASIDE Psychotherapy
LIMITED LIABILITY COMPANY

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AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

Patient Name	Date of Birth	Parent/Guardian (if minor)

I voluntarily authorize Seaside Psychotherapy LLC to (initial appropriate item) ___ request from / ___ release to / ___ exchange with the following person or entity my protected health information (PHI):	
Name	
Street Address	
City/State/Zip	
Phone	
Fax	

I place my initial next to the information to be obtained or released.			
☐ All associated PHI	☐ Medical records	☐ Discharge summary	☐ Initial evaluation
☐ Progress notes	☐ Educational records	☐ Laboratory reports	☐ School records
☐Other (specify):			

I place my initial next to the intended purpose of information to be obtained or released.		
☐ Continuity of care	☐ Case management	☐ Other (specify):
This authorization is valid for ninety (90) days or valid until this specified date:		

By signing this form, I consent to the release of the above specified information from my records. I further absolve Seaside Psychotherapy LLC from any liability arising from the release of this information. I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, and/or drug and alcohol use (in accordance with the Healthy Information Portability Accountability Act. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, or drug and/or alcohol use, Seaside Psychotherapy LLC is specifically authorized to release all health information relating to such diagnosis, testing, or treatment. I may revoke this at any time in writing, but not to the extent of previous disclosure. Prohibition of Redisclosure – "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose".

Patient Signature	
Parent/Guardian Signature	
Witness Signature	
Date Signed	